J. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

II. Physician Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CM) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). If here is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(2) RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not applicable
Anesthesia (except delivery related)	$29.02
All Other Services	$29.67

C. Reimbursement Exceptions.

(1) Physicians will be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of twenty-one (21), with reimbursement for the cost of the drugs made by the Department for Medicaid Services to the Department for Public Health upon receipt of notice from the physicians that the drugs were used to provide immunizations to Medicaid recipients.

(2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	$870.00
Vaginal delivery including postpartum care	$900.00
Cesarean delivery only	$870.00
Cesarean delivery including postpartum care	$900.00

(3) For delivery-related anesthesia services provided on or after July 1, 1995, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	$200.00
Epidural single	$315.00
Epidural continuous	$335.00
Cesarean section	$320.00

(4) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

(8) Payments for the injection procedure for chemonucleolysis of invertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of $793.50 as established by the Department.

(9) Specified family planning procedures performed in the physician office seting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.

(10) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(12) For a practice-related service provided by a physician assistant, the participating physician shall be reimbursed at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.

(13) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

D. Assurances. The state hereby assures that (1) payment for physician services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in he locality for comparable services under comparable circumstances (42 CFR 447.325).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 9 — 0 3

2. STATE: KY

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
4/1/99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.271
1923(g) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 89 $ 17.5 million
b. FFY 00 $ 17.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 8
Attachment 4.19-A, Page 9
Attachment 4.19-A, Exhibit A, page 102B.03

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 8
Attachment 4.19-A, Exhibit A, page 102B.03

10. SUBJECT OF AMENDMENT:
Payments for Inpatient Hospital SErvices

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner Dept for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:
Policy Coordination Branch
Department for Medicaid SErvices
2275 East Main Street
CHR Bldg - 6th Floor East
Frankfort KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 29, 1999

18. DATE APPROVED:
DEEMED APPROVED — March 2, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

(12) Intensity Operating Allowance Inpatient Supplement.

During the final quarter of SFY 1999, instead of the additional payment amount provided for under Section (5)B.2 of this attachment, any qualifying hospital that meets the additional criteria of a Type III hospital as described in Attachment 4.19-A, Exhibit A, Section 102B.(d) (3), shall receive a supplemental payment for the current rate year. This supplement shall be an amount established according to the following method and shall be distributed to qualifying hospitals as described below.

A qualifying hospital's pediatric teaching supplement =
2% of the per diem rate X Medicaid utilization rate X Medicaid patient days.

Medicaid utilization rate for the above calculation is the rate derived by dividing a hospital's total Medicaid days by the total patient days. *Medicaid patient days* include days reimbursed through a managed care entity and the fee-for-service reimbursement methodology.

Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

Subsequent payments made under this section shall be prospectively determined quarterly amounts and shall be subject to the same limitations and conditions as above.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

13) Payment Not To Exceed Charges

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges-plus-disproportionate share.

14) Limit on Amount of Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. The amount of disproportionate share payments that exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Section 1923 (g) of the Social Security Act.)

Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments. If payments exceed costs, the financial gain from Medicaid will not be applied against the unrecovered cost of uninsured/indigent patients.

Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. If payment exceeds cost, the financial gain will not be applied against the Medicaid payment shortfall. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

SECTION 102B. DISPROPORTIONATE SHARE HOSPITALS

(2) State university teaching hospitals having Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of paid Medicaid days shall have an upper limit set at 126 percent of the weighted median per diem cost for hospitals of 401 beds or more. Any state designated pediatric teaching hospitals shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective, reasonably determined uncompensated Medicaid cost to the facility. For the rate year ending June 30, 1999, any state designated state pediatric hospital further meeting the qualifications of a Type III hospital, instead of the above, shall be paid a supplemental payment in an amount equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the Medicaid charges of the hospital. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid, if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A).